

**Introduced by Senators Alquist and Pavley**

February 27, 2009

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An act to amend Sections 1366.35 and 1399.801 of, and to repeal Section 1399.818 of, the Health and Safety Code, and to amend Sections 10785 and 10900 of, and to repeal Section 10902.6 of, the Insurance Code, relating to health care coverage.

**LEGISLATIVE COUNSEL'S DIGEST**

SB 796, as introduced, Alquist. Health care coverage: continuation coverage.

Existing law provides for licensing and regulation of health care service plans by the Department of Managed Health Care. Existing law provides for licensing and regulation of health insurers by the Insurance Commissioner. A willful violation of provisions governing health care service plans is a crime.

Existing law requires health care service plans and health insurers to offer continuation of group coverage for a specified period of time to persons who become ineligible for the group coverage, otherwise known as COBRA or Cal-COBRA. Existing law allows persons qualifying as "federally eligible defined individuals" for purposes of the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) to enroll in individual health care coverage offered by plans and insurers without preexisting condition exclusions, providing they meet certain requirements, including the election and exhaustion of COBRA or Cal-COBRA coverage available to them.

This bill would delete the requirement that a person must elect and exhaust COBRA or Cal-COBRA coverage in order to qualify for access to individual health care coverage as a federally eligible defined individual under HIPAA. By modifying the requirements applicable to

health care service plans, the bill would change the definition of a crime and would thereby impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority. Appropriation: no. Fiscal committee: yes.  
State-mandated local program: yes.

*The people of the State of California do enact as follows:*

- 1     SECTION 1. Section 1366.35 of the Health and Safety Code  
2     is amended to read:  
3     1366.35. (a) A health care service plan providing coverage  
4     for hospital, medical, or surgical benefits under an individual health  
5     care service plan contract may not, with respect to a federally  
6     eligible defined individual desiring to enroll in individual health  
7     insurance coverage, decline to offer coverage to, or deny enrollment  
8     of, the individual or impose any preexisting condition exclusion  
9     with respect to the coverage.  
10    (b) For purposes of this section, “federally eligible defined  
11    individual” means an individual who, as of the date on which the  
12    individual seeks coverage under this section, meets all of the  
13    following conditions:  
14    (1) Has had 18 or more months of creditable coverage, and  
15    whose most recent prior creditable coverage was under a group  
16    health plan, a federal governmental plan maintained for federal  
17    employees, or a governmental plan or church plan as defined in  
18    the federal Employee Retirement Income Security Act of 1974  
19    (29 U.S.C. Sec. 1002).  
20    (2) Is not eligible for coverage under a group health plan,  
21    Medicare, or Medi-Cal, and does not have other health insurance  
22    coverage.  
23    (3) Was not terminated from his or her most recent creditable  
24    coverage due to nonpayment of premiums or fraud.  
25    ~~(4) If offered continuation coverage under COBRA or~~  
26    ~~Cal-COBRA, has elected and exhausted that coverage.~~  
27    (c) Every health care service plan shall comply with applicable  
28    federal statutes and regulations regarding the provision of coverage

1 to federally eligible defined individuals, including any relevant  
2 application periods.

3 (d) A health care service plan shall offer the following health  
4 benefit plan contracts under this section that are designed for, made  
5 generally available to, are actively marketed to, and enroll,  
6 individuals: (1) either the two most popular products as defined  
7 in Section 300gg-41(c)(2) of Title 42 of the United States Code  
8 and Section 148.120(c)(2) of Title 45 of the Code of Federal  
9 Regulations or (2) the two most representative products as defined  
10 in Section 300gg-41(c)(3) of the United States Code and Section  
11 148.120(c)(3) of Title 45 of the Code of Federal Regulations, as  
12 determined by the plan in compliance with federal law. A health  
13 care service plan that offers only one health benefit plan contract  
14 to individuals, excluding health benefit plans offered to Medi-Cal  
15 or Medicare beneficiaries, shall be deemed to be in compliance  
16 with this article if it offers that health benefit plan contract to  
17 federally eligible defined individuals in a manner consistent with  
18 this article.

19 (e) (1) In the case of a health care service plan that offers  
20 health insurance coverage in the individual market through a  
21 network plan, the plan may do both of the following:

22 (A) Limit the individuals who may be enrolled under that  
23 coverage to those who live, reside, or work within the service area  
24 for the network plan.

25 (B) Within the service area of the plan, deny coverage to  
26 individuals if the plan has demonstrated to the director that the  
27 plan will not have the capacity to deliver services adequately to  
28 additional individual enrollees because of its obligations to existing  
29 group contractholders and enrollees and individual enrollees, and  
30 that the plan is applying this paragraph uniformly to individuals  
31 without regard to any health status related factor of the individuals  
32 and without regard to whether the individuals are federally eligible  
33 defined individuals.

34 (2) A health care service plan, upon denying health insurance  
35 coverage in any service area in accordance with subparagraph (B)  
36 of paragraph (1), may not offer coverage in the individual market  
37 within that service area for a period of 180 days after the coverage  
38 is denied.

39 (f) (1) A health care service plan may deny health insurance  
40 coverage in the individual market to a federally eligible defined

1 individual if the plan has demonstrated to the director both of the  
2 following:

3 (A) The plan does not have the financial reserves necessary to  
4 underwrite additional coverage.

5 (B) The plan is applying this subdivision uniformly to all  
6 individuals in the individual market and without regard to any  
7 health status-related factor of the individuals and without regard  
8 to whether the individuals are federally eligible individuals.

9 (2) A health care service plan, upon denying individual health  
10 insurance coverage in any service area in accordance with  
11 paragraph (1), may not offer that coverage in the individual market  
12 within that service area for a period of 180 days after the date the  
13 coverage is denied or until the issuer has demonstrated to the  
14 director that the plan has sufficient financial reserves to underwrite  
15 additional coverage, whichever is later.

16 (g) The requirement pursuant to federal law to furnish a  
17 certificate of creditable coverage shall apply to health insurance  
18 coverage offered by a health care service plan in the individual  
19 market in the same manner as it applies to a health care service  
20 plan in connection with a group health benefit plan.

21 (h) A health care service plan shall compensate a life agent or  
22 fire and casualty broker-agent whose activities result in the  
23 enrollment of federally eligible defined individuals in the same  
24 manner and consistent with the renewal commission amounts as  
25 the plan compensates life agents or fire and casualty broker-agents  
26 for other enrollees who are not federally eligible defined  
27 individuals and who are purchasing the same individual health  
28 benefit plan contract.

29 (i) Every health care service plan shall disclose as part of its  
30 COBRA or Cal-COBRA disclosure and enrollment documents,  
31 an explanation of the availability of guaranteed access to coverage  
32 under the Health Insurance Portability and Accountability Act of  
33 1996, ~~including the necessity to enroll in and exhaust COBRA or~~  
34 ~~Cal-COBRA benefits~~ in order to become a federally eligible  
35 defined individual.

36 (j) No health care service plan may request documentation as  
37 to whether or not a person is a federally eligible defined individual  
38 other than is permitted under applicable federal law or regulations.

(k) This section shall not apply to coverage defined as excepted benefits pursuant to Section 300gg(c) of Title 42 of the United States Code.

~~(l) This section shall apply to health care service plan contracts offered, delivered, amended, or renewed on or after January 1, 2001.~~

SEC. 2. Section 1399.801 of the Health and Safety Code is amended to read:

1399.801. As used in this article:

(a) “Creditable coverage” means:

(1) Any individual or group policy, contract, or program that is written or administered by a disability insurer, health care service plan, fraternal benefits society, self-insured employer plan, or any other entity, in this state or elsewhere, and that arranges or provides medical, hospital, and surgical coverage not designed to supplement other plans. The term includes continuation or conversion coverage but does not include accident only, credit, disability income, Medicare supplement, long-term care, dental, vision, coverage issued as a supplement to liability insurance, insurance arising out of a workers’ compensation or similar law, automobile medical payment insurance, or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

(2) The federal Medicare program pursuant to Title XVIII of the Social Security Act.

(3) The medicaid program pursuant to Title XIX of the Social Security Act.

(4) Any other publicly sponsored program, provided in this state or elsewhere, of medical, hospital, and surgical care.

(5) 10 U.S.C.A. Chapter 55 (commencing with Section 1071) (CHAMPUS).

(6) A medical care program of the Indian Health Service or of a tribal organization.

(7) A state health benefits risk pool.

(8) A health plan offered under 5 U.S.C.A. Chapter 89 (commencing with Section 8901) (FEHBP).

(9) A public health plan as defined in federal regulations authorized by Section 2701(c)(1)(l) of the Public Health Service

1 Act, as amended by Public Law 104-191, the Health Insurance  
2 Portability and Accountability Act of 1996.

3 (10) A health benefit plan under 22 U.S.C.A. 2504(e) of the  
4 Peace Corps Act.

5 (b) “Dependent” means the spouse or child of an eligible  
6 individual or other individual applying for coverage, subject to  
7 applicable terms of the health care plan contract covering the  
8 eligible person.

9 (c) “Federally eligible defined individual” means an individual  
10 who as of the date on which the individual seeks coverage under  
11 this part, (1) has 18 or more months of creditable coverage, and  
12 whose most recent prior creditable coverage was under a group  
13 health plan, a federal governmental plan maintained for federal  
14 employees, or a governmental plan or church plan as defined in  
15 the federal Employee Retirement Income Security Act of 1974  
16 (29 U.S.C. Sec. 1002), (2) is not eligible for coverage under a  
17 group health plan, Medicare, or Medi-Cal, and has no other health  
18 insurance coverage, *and* (3) was not terminated from his or her  
19 most recent creditable coverage due to nonpayment of premiums  
20 or fraud; ~~and (4) if offered continuation coverage under COBRA~~  
21 ~~or Cal-COBRA, had elected and exhausted this coverage.~~

22 (d) “In force business” means an existing health benefit plan  
23 contract issued by the plan to a federally eligible defined individual.

24 (e) “New business” means a health care service plan contract  
25 issued to an eligible individual that is not the plan’s in force  
26 business.

27 (f) “Preexisting condition provision” means a contract provision  
28 that excludes coverage for charges and expenses incurred during  
29 a specified period following the eligible individual’s effective date,  
30 as to a condition for which medical advice, diagnosis, and care of  
31 treatment was recommended or received during a specified period  
32 immediately preceding the effective date of coverage.

33 SEC. 3. Section 1399.818 of the Health and Safety Code is  
34 repealed.

35 ~~1399.818. This article shall apply to health care service plan~~  
36 ~~contracts offered, delivered, amended, or renewed on or after~~  
37 ~~January 1, 2001.~~

38 SEC. 4. Section 10785 of the Insurance Code is amended to  
39 read:

1 10785. (a) A disability insurer that covers hospital, medical,  
2 or surgical expenses under an individual health benefit plan as  
3 defined in subdivision (a) of Section 10198.6 may not, with respect  
4 to a federally eligible defined individual desiring to enroll in  
5 individual health insurance coverage, decline to offer coverage to,  
6 or deny enrollment of, the individual or impose any preexisting  
7 condition exclusion with respect to the coverage.

8 (b) For purposes of this section, “federally eligible defined  
9 individual” means an individual who, as of the date on which the  
10 individual seeks coverage under this section, meets all of the  
11 following conditions:

12 (1) Has had 18 or more months of creditable coverage, and  
13 whose most recent prior creditable coverage was under a group  
14 health plan, a federal governmental plan maintained for federal  
15 employees, or a governmental plan or church plan as defined in  
16 the federal Employee Retirement Income Security Act of 1974  
17 (29 U.S.C. Sec. 1002).

18 (2) Is not eligible for coverage under a group health plan,  
19 Medicare, or Medi-Cal, and does not have other health insurance  
20 coverage.

21 (3) Was not terminated from his or her most recent creditable  
22 coverage due to nonpayment of premiums or fraud.

23 ~~(4) If offered continuation coverage under COBRA or~~  
24 ~~Cal-COBRA, has elected and exhausted that coverage.~~

25 (c) Every disability insurer that covers hospital, medical, or  
26 surgical expenses shall comply with applicable federal statutes  
27 and regulations regarding the provision of coverage to federally  
28 eligible defined individuals, including any relevant application  
29 periods.

30 (d) A disability insurer shall offer the following health benefit  
31 plans under this section that are designed for, made generally  
32 available to, are actively marketed to, and enroll, individuals:

33 (1) either the two most popular products as defined in Section  
34 300gg-41(c)(2) of Title 42 of the United States Code and Section  
35 148.120(c)(2) of Title 45 of the Code of Federal Regulations or

36 (2) the two most representative products as defined in Section  
37 300gg-41(c)(3) of the United States Code and Section  
38 148.120(c)(3) of Title 45 of the Code of Federal Regulations, as  
39 determined by the insurer in compliance with federal law. An  
40 insurer that offers only one health benefit plan to individuals,

1 excluding health benefit plans offered to Medi-Cal or Medicare  
2 beneficiaries, shall be deemed to be in compliance with this chapter  
3 if it offers that health benefit plan contract to federally eligible  
4 defined individuals in a manner consistent with this chapter.

5 (e) (1) In the case of a disability insurer that offers health benefit  
6 plans in the individual market through a network plan, the insurer  
7 may do both of the following:

8 (A) Limit the individuals who may be enrolled under that  
9 coverage to those who live, reside, or work within the service area  
10 for the network plan.

11 (B) Within the service area covered by the health benefit plan,  
12 deny coverage to individuals if the insurer has demonstrated to the  
13 commissioner that the insured will not have the capacity to deliver  
14 services adequately to additional individual insureds because of  
15 its obligations to existing group policyholders, group  
16 contractholders and insureds, and individual insureds, and that the  
17 insurer is applying this paragraph uniformly to individuals without  
18 regard to any health status-related factor of the individuals and  
19 without regard to whether the individuals are federally eligible  
20 defined individuals.

21 (2) A disability insurer, upon denying health insurance coverage  
22 in any service area in accordance with subparagraph (B) of  
23 paragraph (1), may not offer health benefit plans through a network  
24 in the individual market within that service area for a period of  
25 180 days after the coverage is denied.

26 (f) (1) A disability insurer may deny health insurance coverage  
27 in the individual market to a federally eligible defined individual  
28 if the insurer has demonstrated to the commissioner both of the  
29 following:

30 (A) The insurer does not have the financial reserves necessary  
31 to underwrite additional coverage.

32 (B) The insurer is applying this subdivision uniformly to all  
33 individuals in the individual market and without regard to any  
34 health status-related factor of the individuals and without regard  
35 to whether the individuals are federally eligible defined individuals.

36 (2) A disability insurer, upon denying individual health  
37 insurance coverage in any service area in accordance with  
38 paragraph (1), may not offer that coverage in the individual market  
39 within that service area for a period of 180 days after the date the  
40 coverage is denied or until the insurer has demonstrated to the



1 commissioner that the insurer has sufficient financial reserves to  
2 underwrite additional coverage, whichever is later.

3 (g) The requirement pursuant to federal law to furnish a  
4 certificate of creditable coverage shall apply to health benefits  
5 plans offered by a disability insurer in the individual market in the  
6 same manner as it applies to an insurer in connection with a group  
7 health benefit plan policy or group health benefit plan contract.

8 (h) A disability insurer shall compensate a life agent or fire and  
9 casualty broker-agent whose activities result in the enrollment of  
10 federally eligible defined individuals in the same manner and  
11 consistent with the renewal commission amounts as the insurer  
12 compensates life agents or fire and casualty broker-agents for other  
13 enrollees who are not federally eligible defined individuals and  
14 who are purchasing the same individual health benefit plan.

15 (i) Every disability insurer shall disclose as part of its COBRA  
16 or Cal-COBRA disclosure and enrollment documents, an  
17 explanation of the availability of guaranteed access to coverage  
18 under the Health Insurance Portability and Accountability Act of  
19 1996, ~~including the necessity to enroll in and exhaust COBRA or~~  
20 ~~Cal-COBRA benefits in order to become a federally eligible~~  
21 ~~defined individual.~~

22 (j) No disability insurer may request documentation as to  
23 whether or not a person is a federally eligible defined individual  
24 other than is permitted under applicable federal law or regulations.

25 (k) This section shall not apply to coverage defined as excepted  
26 benefits pursuant to Section 300gg(c) of Title 42 of the United  
27 States Code.

28 ~~(l) This section shall apply to policies or contracts offered,~~  
29 ~~delivered, amended, or renewed on or after January 1, 2001.~~

30 SEC. 5. Section 10900 of the Insurance Code is amended to  
31 read:

32 10900. As used in this chapter:

33 (a) "Benefit plan design" means a specific health coverage  
34 policy issued by a carrier to individuals, to trustees of associations  
35 that cover individuals. It includes services covered and the levels  
36 of copayment and deductibles, and it may include the professional  
37 providers who are to provide those services and the sites where  
38 those services are to be provided. A benefit plan design may also  
39 be an integrated system for the financing and delivery of quality

1 health services that has significant incentives for the covered  
2 individuals to use the system.

3 (b) “Carrier” means any disability insurance company or any  
4 other entity that writes, issues, or administers health benefit plans,  
5 as defined in subdivision (a) of Section 10198.6, that cover  
6 individuals, regardless of the situs of the contract or master  
7 policyholder.

8 (c) “Creditable coverage” means:

9 (1) Any individual or group policy, contract, or program that is  
10 written or administered by a disability insurer, health care service  
11 plan, fraternal benefits society, self-insured employer plan, or any  
12 other entity, in this state or elsewhere, and that arranges or provides  
13 medical, hospital, and surgical coverage not designed to supplement  
14 other plans. The term includes continuation or conversion coverage  
15 but does not include accident only, credit, disability income,  
16 Champus supplement, Medicare supplement, long-term care,  
17 dental, vision, coverage issued as a supplement to liability  
18 insurance, insurance arising out of a workers’ compensation or  
19 similar law, automobile medical payment insurance, or insurance  
20 under which benefits are payable with or without regard to fault  
21 and that is statutorily required to be contained in any liability  
22 insurance policy or equivalent self-insurance.

23 (2) The federal Medicare program pursuant to Title XVIII of  
24 the Social Security Act.

25 (3) The medicaid program pursuant to Title XIX of the Social  
26 Security Act.

27 (4) Any other publicly sponsored program, provided in this state  
28 or elsewhere, of medical, hospital, and surgical care.

29 (5) 10 U.S.C.A. Chapter 55 (commencing with Section 1071)  
30 (CHAMPUS).

31 (6) A medical care program of the Indian Health Service or of  
32 a tribal organization.

33 (7) A state health benefits risk pool.

34 (8) A health plan offered under 5 U.S.C.A. Chapter 89  
35 (commencing with Section 8901) (FEHBP).

36 (9) A public health plan as defined in federal regulations  
37 authorized by Section 2701(c)(1)(I) of the Public Health Service  
38 Act, as amended by Public Law 104-191.

39 (10) A health benefit plan under Section 5(e) of the Peace Corps  
40 Act (22 U.S.C.A. 2504(e)).

1 (d) “Dependent” means the spouse or child of an eligible  
2 individual or other individual applying for coverage, subject to  
3 applicable terms of the health benefit plan covering the eligible  
4 person.

5 (e) “Federally eligible defined individual” means an individual  
6 who as of the date on which the individual seeks coverage under  
7 this part, (1) has 18 or more months of creditable coverage, and  
8 whose most recent prior creditable coverage was under a group  
9 health plan, a federal governmental plan maintained for federal  
10 employees, or a governmental plan or church plan as defined in  
11 the federal Employee Retirement Income Security Act of 1974  
12 (29 U.S.C. Sec. 1002), (2) is not eligible for coverage under an  
13 employer-sponsored health benefit plan, Medicare, or Medi-Cal,  
14 and has no other health insurance coverage, and (3) was not  
15 terminated from his or her most recent creditable coverage due to  
16 nonpayment of premiums or fraud, ~~and (4) if offered continuation~~  
17 ~~coverage under COBRA or Cal-COBRA, had elected and~~  
18 ~~exhausted such coverage.~~

19 (f) “In force business” means an existing health benefit plan  
20 issued by a carrier to a federally eligible defined individual.

21 (g) “New business” means a health benefit plan issued to an  
22 eligible individual that is not the carrier’s in force business.

23 (h) “Preexisting condition provision” means a policy provision  
24 that excludes coverage for charges and expenses incurred during  
25 a specified period following the eligible individual’s effective date,  
26 as to a condition for which medical advice, diagnosis, care, or  
27 treatment was recommended or received during a specified period  
28 immediately preceding the effective date of coverage.

29 SEC. 6. Section 10902.6 of the Insurance Code is repealed.

30 ~~10902.6. This chapter shall apply to policies or contracts~~  
31 ~~offered, delivered, amended, or renewed on or after January 1,~~  
32 ~~2001.~~

33 SEC. 7. The changes made by Sections 1, 2, 4, and 5 of this  
34 act shall apply to plan contracts, or policies or contracts, as the  
35 case may be, that are offered, delivered, amended, or renewed on  
36 or after January 1, 2010.

37 SEC. 8. No reimbursement is required by this act pursuant to  
38 Section 6 of Article XIII B of the California Constitution because  
39 the only costs that may be incurred by a local agency or school  
40 district will be incurred because this act creates a new crime or

1   infraction, eliminates a crime or infraction, or changes the penalty  
2   for a crime or infraction, within the meaning of Section 17556 of  
3   the Government Code, or changes the definition of a crime within  
4   the meaning of Section 6 of Article XIII B of the California  
5   Constitution.

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